



TennCare Operational Protocol

Chapter 6: Administration

<p style="text-align: center;">Section 6.1</p> <p style="text-align: center;">Administration and Management Systems</p>

6.1.1 Overview

This chapter provides a description of the TennCare Management Information System (TCMIS), including a discussion of the system design and explanation of how the system interfaces with outside agencies and providers. In addition, this chapter will describe HIPAA compliance activities that have been completed and those scheduled to be completed during the course of the Demonstration.

The TCMIS is maintained and operated by an outside contractor, performing as the Facilities Manager. The TCMIS has the flexibility to support project management as well as TennCare Demonstration and reform modifications, such as multiple benefit plans and carve-out programs.

6.1.2 Information System Modules

The TCMIS is designed to meet the complex management and information needs of TennCare and has the capability to administer multiple benefits packages. This functionality is necessary to manage benefits service limits and optional benefit riders (e.g. optional dental benefits and pharmacy benefits only). The TCMIS also automates many existing processes, such as imaging of letters generated to recipients and providers.

A description of the TCMIS major functions is provided below.

6.1.2.1 Eligibility

The TCMIS houses the master eligibility file for TennCare. This sub-system maintains and updates day-specific eligibility information for the TennCare Medicaid and TennCare Standard populations, as well as for SSI populations, including Medicare beneficiaries. Updates to the TennCare eligibility master file are currently received from multiple sources: DHS, DOH, DCS, SSA, DMRS and DMHDD. The eligibility subsystem is used for all functions that require eligibility and enrollment data (e.g., claims processing, enrollment processing, and capitation payments). The system's maintenance function is to accept and maintain accurate, current and historical source data on eligibility information.

The major eligibility and enrollment functions of the TCMIS are to:

- Establish and maintain a single client identifier for each person that can be associated with historical identifiers and other family members.
- Track all categories of eligibility, with begin and end dates for each category.
- Manage acceptance of Medicare, TennCare Medicaid and TennCare Standard eligibility records and updates from internal and external agencies.

- Process eligibility and maintenance updates from DHS, DCS, DMHDD, DMRS, and SSA, maintaining historical eligibility data from each.
- Use eligibility information for notice generation for redetermining eligibility for the TennCare Standard population annually or upon a qualifying event, if needed.
- Process MCO/BHO/PBM/DBM enrollment/disenrollment.
- Assign enrollees to a Managed Care Contractor and generate MCO/BHO/PBM/DBM enrollment rosters.
- Assure that demographic information is maintained and identifiable by data source.
- Identify persons with special needs or in special populations.
- Collect and distribute third party liability information.

The eligibility and enrollment sub-system accepts the following eligibility data:

- TennCare Medicaid and TennCare Standard eligibility data from the Department of Human Services ACCENT system.
- Presumptive eligibility for pregnant women from the Department of Health.
- Patient liability information from DHS and long-term care facilities.
- SSI eligibility data from the Social Security Administration.
- DCS immediate eligibility data from the Department of Children's Services (TnKIDS system).
- Breast and Cervical Cancer Treatment eligibility data from the Department of Human Services.
- Severely and/or Persistently Mentally Ill (SPMI) and Seriously Emotionally Disturbed (SED) Eligibility data from the Tennessee Department of Mental Health and Developmental Disabilities (MHDD).
- Buy-In eligibility data from the Centers for Medicare and Medicaid Services.

This subsystem will also interface with the federal Department of Defense, Managed Care Organizations, Behavioral Health Organizations, Pharmacy Claims Processor, and Dental Benefits Manager to obtain enrollee information regarding third-party resources, Medicare benefits and buy-in eligibility. The subsystem also interfaces with the Beneficiary Data Exchange (BENDEX), which is a computer match by Social Security numbers (SSN) of the individuals applying for or already on TennCare. The External Quality Review Organization (EQRO) also interfaces with this subsystem in the performance of its activities.

6.1.2.2 Encounter Data Processing

The encounter data subsystem collects, validates and processes encounter data submitted by Managed Care Organizations, Behavioral Health Organizations and the state's Pharmacy and Dental Benefit Managers. These contractors must transfer applicable encounter data files to TCMIS using ASC X12N and NCPDP formats.

TCMIS validates the accuracy of CPT codes, HCPCS codes, Revenue Codes, ICD-9-CM codes and ADA-CDT codes. All encounter data also goes through several edit processes, including all seven levels of HIPAA compliance testing and additional edits for content and duplication.

6.1.2.3 Claims Processing

The TCMIS has the capacity to receive, track, and process paper or electronic claims. TCMIS adjudicates claims from: Nursing Facilities for Level 1 and Level 2 Nursing Facility claims, the Division of Mental Retardation Services for MR provider payments, Home and Community Based Services Waiver Providers, DCS, Commission on Aging, ICF/MR claims, and the COBA Program for Medicare professional cross-overs and Medicare institutional cross-over claims. The system receives and translates claims in accepted HIPAA transaction formats.

6.1.2.4 Provider Enrollment

The provider enrollment subsystem maintains provider numbers for Medicare crossover providers, out-of-state providers and TennCare Only providers. All providers contracting with a TennCare MCC must obtain a TennCare provider number, regardless of whether the MCC tracks or identifies the provider by an alternate number. The subsystem aggregates information from provider application and enrollment forms, provider network files submitted by MCCs, initial enrollment from the Medicare Intermediary and Carrier data, the Medicare Provider Sanction List from CMS, the CMS Clinical Laboratory Improvement Act database, Tennessee Department of Children's Services, Tennessee Department of Mental Health and Developmental Disabilities, and Tennessee Department of Health provider data. The Provider Enrollment file is used to monitor provider networks, generate provider mailings, track and report provider enrollment statistics, and to process claims and encounter information.

6.1.2.5 Third Party Liability

The Third Party Liability (TPL) subsystem ensures that TennCare is the payer of last resort for services provided to TennCare enrollees. TPL information is maintained in TCMIS to provide the capability to manage cost avoidance and cost recoveries of claims paid.

6.1.4 Production and Ad Hoc Reporting

The TennCare production and ad hoc reporting systems support a variety of activities. TCMIS reporting capabilities are used to produce routine management reports, operational reports and required federal and state reports; to monitor MCC performance; and to support financial and clinical studies.

6.1.4.1 Federal Reporting Requirements

The federal reports listed below are produced from data stored in TCMIS and affiliated systems. A description of these reports can be found in section 6.4.

- Medicaid Program Budget Report – CMS-37
- Quarterly Expense Report – CMS-64
- Annual Report on Home and Community-Based Services Waivers – CMS-372 and CMS-372(s)

- EPSDT Report – CMS-416
- Quarterly Person-Specific Eligibility and Paid Claims Data – CMS-2082 (MSIS)

6.1.5 MCO/BHO Monitoring

TCMIS assists several Bureau of TennCare divisions in completing their MCC monitoring activities, including:

- Monitoring MCC program administration
- Monitoring enrollment growth, expenditures and cost trends
- Monitoring provider network adequacy
- Monitoring quality and access to care
- Monitoring contract compliance

Additionally, the Tennessee Department of Commerce and Insurance monitors the financial solvency of the MCCs, analyzes their annual financial statements, and performs onsite audits of their claims processing for accuracy and timeliness of processing.

6.1.6 EPSDT Tracking System

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides health screenings and treatment services to TennCare enrollees under the age of 21 to promote early detection of potentially chronic and disabling health conditions. The responsibility for providing EPSDT services to TennCare enrollees has been contracted to the MCOs, with the Quality Oversight Unit performing EPSDT monitoring activities to ensure compliance with federal EPSDT requirements.

TCMIS includes an EPSDT component to support the collection and maintenance of information related to EPSDT and immunization appointments and services. The system includes a mechanism to track whether persons are missing services and to generate reminder notices about upcoming and overdue appointments. This centralized system provides TennCare with the ability to track EPSDT and immunization status as members transfer from one MCO or BHO to another.

6.1.7 HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires state Medicaid programs to protect confidentiality and security of personal health information. The administrative simplification provision of HIPAA also requires state Medicaid programs to standardize the process for the submission and processing of Medicaid claims and other transactions.

The Bureau of TennCare has assumed responsibility for HIPAA compliance with respect to the TennCare program and its enrollees. Accordingly, the Bureau of TennCare has implemented appropriate physical, technical, and administrative safeguards to ensure confidentiality and security of information relating to TennCare enrollees. The Bureau of

TennCare MMIS supports current HIPAA transaction format standards for required transactions. This system provides configurable logging for audit purposes and supports granular definitions of access to ensure the appropriate use of data. The system provides configurable logging for audit purposes and supports granular definitions of access to ensure the appropriate use of data. The system also employs a flexible translator module in order to accommodate future transaction standards, including version upgrades of transaction formats.

The Bureau of TennCare will continue to develop processes and policies to protect information relating to TennCare enrollees.

Section 6.2

Budget Neutrality

The Bureau of TennCare is responsible for assuring that major expenditures remain within the federal financial participation (FFP) cap. The Bureau of TennCare's Health Informatics and Fiscal Services Division have primary responsibility for monitoring TennCare budget neutrality. The process for performing this function is that which has been laid out by CMS.

To assure budget neutrality under the TennCare Demonstration, Tennessee will be using, in general, a per capita cost method and demonstration budget targets will be set on a yearly basis, with a cumulative five-year budget limit.

Reference: See STC # 58.

Individuals who are eligible under the Demonstration will be one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid state plan; (2) those who could be eligible for Medicaid if Tennessee amended its state plan; and (3) those who could not be eligible without section 1115 authority. Tennessee will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Tennessee will not be at risk for changing economic conditions. However, by placing Tennessee at risk for the per capita costs for current eligibles, CMS assures that the Demonstration expenditures do not exceed the level of expenditures had there been no Demonstration. Tennessee will be at risk for both enrollment and expenditure growth for Demonstration eligibles who could not be eligible without section 1115 authority (as defined by group 3 above).

Reference: See STC #s 59 & 60.

Each yearly ceiling for TennCare will be the sum of two budget components: (A) the projected cost of services by specified Medicaid Eligibility Groups (MEGs); and (B) the projected Disproportionate Share Hospital (DSH) adjustment. Each of these components has a distinct method for projecting costs into the future. Administrative costs under the Demonstration will be excluded from the budget neutrality formula except as explained elsewhere.

Reference: See STC # 61a.

There are two steps involved in the calculation of the projected cost of services budget limit referenced in A above: (1) determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and (2) determining the method for inflating these estimates over time.

The following table gives the projected per member per month (PMPM) costs, by Demonstration Year (DY), for the projected cost of services by specified Medicaid Eligibility Groups (MEGs). The PMPM costs for DY 5 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions.

	Trend	DY 5	DY 6	DY 7	DY 8
EG1 Disabled	6.90%	\$987.35	\$1,055.48	\$1,128.31	\$1,206.16
EG2 Over 65	6.18%	\$403.74	\$428.69	\$455.18	\$483.31
EG3 Children	6.48%	\$312.95	\$333.23	\$354.82	\$377.81
EG4 Adults	6.13%	\$613.43	\$651.03	\$690.94	\$733.29
EG5 Duals	6.67%	\$89.82	\$95.81	\$102.20	\$109.02
EG8 Med Exp Child*	6.48%	\$312.95	\$333.23	\$354.82	\$377.81

*Optional Targeted Low Income Children funded using title XIX (See STC # 61c)

The annual limit on Medicaid expenditures will be the sum of the DSH (Disproportionate Share Hospital) adjustment for that year and the products of the inflated per capita cost estimate for that year times the number of Medicaid eligibles (limited to those who would have been eligible without the Demonstration, including optional populations that could have been authorized under state plan amendments) for each of the four eligibility groups.

Reference: See STC # 61c.

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the Demonstration (SFY (State Fiscal Year) 2003) is \$413,700,907. The DSH adjustment for each subsequent year shall be the previous demonstration year's adjustment trended by the CPI-U for that year, as published three months after the end of the demonstration year. In this manner, Tennessee will have available funding for DSH adjustments similar to other states. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.

Reference: See STC # 61d

CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care-related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums or regulation with respect to the provision of services covered under this Demonstration. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments

to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Reference: See STC # 62.

Budget neutrality will be determined on a five-year basis. Any annual savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period. The state in its amendment, must demonstrate that the expansion is sustainable, even when the accrued savings from this five-year Demonstration period are exhausted.

Reference: See STC # 63.

CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Years 1 through 6	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 7	Cumulative budget neutrality cap plus:	0.25 percent
Years 1 through 8	Cumulative budget neutrality cap plus:	0 percent

Reference: See STC # 63.

<p style="text-align: center;">Section 6.3 Federal Financial Participation</p>
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In order to receive federal reimbursement for which states are entitled under Title XIX, TennCare shall submit quarterly reports (CMS-37 and CMS-64) to CMS as described below. These reports shall be the vehicle by which TennCare provides regular accounting of all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare.

Reference: See STCs #s 61, 62, 63, & 64.

<p style="text-align: center;">Section 6.4 Financial Reporting</p>
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6.4.1 Medicaid Program Budget Report -- CMS-37

Responsibility: Financial Operations
Frequency: Quarterly

The CMS-37 is a quarterly financial report submitted by TennCare that provides a statement of TennCare's funding requirements for a quarter and estimates matchable Medicaid and TennCare expenditures underlying assumptions for two fiscal years (FYs) -- the current FY and the budget FY. CMS makes federal funds available each quarter based on approved estimates. In order to receive federal financial participation, TennCare must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically.

Reference: STC #53.

6.4.2 Quarterly Expense Report -- CMS-64

Responsibility: Financial Operations
Frequency: Quarterly, within 30 days after the end of each quarter

The CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Title XIX and that reconciles the funding advance made on the basis of the CMS-37 (discussed above) for the same quarter. TennCare reports on this form all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare. When completed, the report shows actual Medicaid and matchable TennCare expenditures made in the preceding quarter. CMS reconciles actual expenditures reported in the CMS-64 with federal funding made available for the corresponding period.

Reference: See STCs #s49 and 50.

6.4.3 Actual CPE

Responsibility: Financial Operations
Frequency: Annually (fiscal year basis), within 12 months of the end of the year

TennCare reports actual hospital certified public expenditures to CMS within 12 months of the end of TennCare's fiscal year. Expenditures are based on hospital cost and revenue data that has been reviewed by the Comptroller of the Treasury. The protocol for this process is currently being negotiated with CMS.

Reference: See STC #54h.

6.4.4 Person-Specific Eligibility and Paid Claims Data – CMS-2082

Responsibility: Information Systems
Frequency: Quarterly

TennCare submits person-specific eligibility and paid claims data to CMS electronically on a quarterly basis. Five files are included in the quarterly submission: eligibility data; inpatient claims; long term institutional care; prescription drug claims; and all other claims.

6.4.5 Annual Report on Home and Community-Based Services Waivers -- CMS-372 and/or CMS-372(s)

Responsibility: Long Term Care Unit
Frequency: Annually, within 18 months after the close of the waiver year

TennCare submits a separate CMS-372/CMS-372(s) for each of its Home and Community Based Services (HCBS) Waiver Programs: the Arlington Home and Community Based Services Waiver for the Mentally Retarded; the Statewide Home and Community Based Services Waiver for the Mentally Retarded; the Self-Determination Waiver for the Mentally Retarded, and the Statewide Home and Community Based Services Waiver for the Elderly and Disabled. These reports are used by CMS to compare the actual number of services and expenditures incurred under the waivers with the original estimates.